STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXX
Petitioner **File No. 86594-001-SF**
v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 1ST day of February 2008
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On December 5, 2007, XXXX, the authorized representative of his wife XXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under Public Act No. 495 of 2006, MCL550.1951 *et seq*. The Commissioner reviewed the material submitted and determined the request was incomplete. After additional material was provided the Commissioner accepted the request on January 9, 2008. As required by section 2(2) of Act 495, the Commissioner conducts this external review according to the provisions of the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.*

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information it used in making its adverse determination. The Office of Financial and Insurance Services received BCBSM's response on January 22, 2008.

The issue in this external review can be decided by analyzing the BCBSM Comprehensive Health Care Copayment Certificate Series CMM 100-90/10, which is amended

by Rider HC Hearing Care, the contract defining the Petitioner's health coverage. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). The case does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On May 31, 2007, the Petitioner purchased hearing aids. The hearing aids were purchased from XXXX Hearing Aid Centers, located in XXXX. The charge in question is $2,800.00. BCBSM denied coverage for the Petitioner's hearing aids.

The Petitioner appealed BCBSM's denial. BCBSM held a managerial-level conference on October 2, 2007, and issued a final adverse determination dated October 12, 2007, confirming its denial of coverage.

III
ISSUE

Did BCBSM correctly deny coverage for the Petitioner's hearing aids purchased on May 31, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner's husband called BCBSM's customer service department in May 2007. He asked if his wife's hearing aids could be replaced under their insurance coverage because the old hearing aids were no longer adequate. The customer service person indicated they were eligible for new hearing aids. Customer service also called the hearing aid center in XXXX to confirm verbally that the benefits had renewed and the doctor was authorized to proceed.

Petitioner says that BCBSM now accepts no responsibility for misleading the Petitioner to believe that her hearing aids are covered. The Petitioner believes that BCBSM is required to pay for the hearing aids.

BCBSM's Argument

The Rider HC states that BCBSM will pay for the audiometric examination, hearing aid evaluation, conformity tests and a hearing aid once every 36 months. BCBSM will consider providing additional hearing care benefits if a physician-specialist sends them documentation of severe hearing loss that has occurred within 36 months.

In the Petitioner's case she had received reimbursement for hearing aids on July 19, 2004. The claim in question is for service date of May 31, 2007, when she purchased the new hearing aids. She was not eligible for new hearing aids until July 2007. No documentation was provided that indicated a severe hearing loss prior to the end of the 36 month period. Therefore, the Petitioner's new hearing aids do not meet the terms of her coverage and are not a covered benefit.

BCBSM does not believe that it mislead the Petitioner to believe that her May 31, 2007 hearing aids would be paid by BCBSM. It could not locate a record in its phone system of a phone call between the hearing aid provider and BCBSM.

Commissioner's Review

Hearing aids are a covered benefit under Rider HC which amends the certificate. However, these devices are only covered when purchased every 36 months. Additional hearing benefits are considered only when there is a documented severe hearing loss. No such documentation was provided in this case. Therefore, since the Petitioner received hearing aids on July 19, 2004 the Commissioner concludes her May 31, 2007 devices were provided within 36 months and are not a covered benefit.

The Petitioner indicates that BCBSM told her husband and her provider in separate phone conversations that she was eligible for new hearing aids in May 2007. BCBSM indicated it did not mislead the Petitioner and they have no record of a telephone conversation with the Petitioner's provider. Under the PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health benefits under the terms of the

applicable insurance contract and state law. Resolution of a factual dispute such as the one described by the Petitioner cannot be part of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds that BCBSM correctly applied the provisions of Petitioner's certificate.

V
ORDER

Respondent BCBSM's final adverse determination of October 12, 2007, is upheld. BCBSM is not required to pay for the hearing aids provided to the Petitioner on May 31, 2007, since they are not covered under the certificate.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.